BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **JOAN M. WARNER, M.D.** Holder of License No **27858** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-05-0511A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on August 9, 2006. Joan M. Warner, M.D., ("Respondent") appeared before the Board with legal counsel Robert Milligan for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 27858 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-05-0511A after being notified a hospital suspended Respondent's privileges based on the care and treatment Respondent rendered to two pregnant patients – a twenty-one year-old female ("HD") and a twenty-six year-old female ("KC").

4. HD presented to the hospital on February 13, 2005 at term with spontaneous rupture of membranes and was admitted by another physician who found she had preeclampsia and started her on magnesium sulfate and Pitocin. Respondent arrived and took over HD's management. HD was given an epidural and there was a bradycardia with lates, but this resolved. Subsequently, late decelerations began again and Respondent was notified

approximately one hour after they started. Respondent elected to do a Cesarean section ("C-section") because of the on-going fetal distress. HD signed an informed consent at 1704. During this time another physician was performing a C-section and, although there were two available operating rooms, there was only one anesthesiologist available. HD continued to have Pitocin administered from when the C-section was originally called until she signed the consent at 1704. Respondent began the delivery at 1810. HD's infant was delivered with Apgars of 3, 8, and 9 and a pH of 6.93. The infant had seizures and was transferred to another hospital where he remained for seven days. By all indications in the record the infant had no further complications.

5. KC presented to the hospital on April 21, 2005 at term with spontaneous rupture of membranes. KC was started on Pitocin and Respondent, the physician on-call, took over KC's management. At 1850 KC was four centimeters and Respondent introduced an intrauterine pressure catheter. A scalp electrode was applied approximately one hour later and KC was complete at 2116. At 2130 an abnormal tracing was noted and by 2225 decreased variability was appreciated. Respondent examined KC at 2251 and noted deep variables with slow return. When KC stopped pushing, these resolved. Respondent left the unit at this point and KC continued to push under nursing instructions. During this time several variables and repetitive late decelerations were appreciated. At 0028 Respondent attempted a vacuum delivery of the infant with results after three attempts. The infant was then spontaneously delivered with Apgars of 2, 2, and 2. The umbilical cord was noted to be avulsed and the infant subsequently died.

6. Since these two deliveries Respondent underwent additional training and her obstetrical privileges were restored. Respondent testified she immediately instituted intrauterine resuscitative measures with HD and then observed her response. Respondent noted there was some mild improvement in the pattern of late decelerations, however, her variability did remain minimal and this was concerning to her. Respondent testified a very significant factor with HD was the magnesium sulfate, which decreases variability. As a result there was some time

required to assess the significance of that. Respondent testified she reviewed those findings and at 1704 made the decision to proceed with the C-section, and she feels that is a very reasonable time to evaluate HD, institute the measures, assess her response, and then counsel her for delivery. Respondent noted there were two labor and delivery suites, but only one anesthesiologist and nurse practitioner.

7. Respondent testified that when she made the decision to do the C-section on HD another physician was taking his patient to the operating room. Respondent noted that knowing how much time it would take to get HD prepped and on the table, and how quickly the team was capable of doing a C-section, she felt it was reasonable to allow the other physician to proceed. Respondent testified the other physician's assistant had not shown up and he asked if she was willing to assist him in order to expedite the case and she agreed. Respondent noted that when she finished assisting in the other delivery, HD had not been taken to the operating room as she had very clearly instructed, so she moved things along and delivered the infant.

8. Respondent testified KC was admitted by another physician and she first assessed her at 1850 and again at 1948. Respondent testified that at that time the tracing looked fine, KC was only four centimeters dilated, and Respondent left the hospital. Respondent testified she came back to the hospital incidentally to do another delivery and, after that delivery, she went to review KC's tracings at 2251. Respondent testified this was the first time she became aware KC had reached complete dilation almost ninety minutes earlier and began pushing. Respondent noted from the minute KC began pushing she had immediate onset of variable decelerations that were very significant – she would classify them as severe. Respondent testified they are a common finding in the second stage of labor, but the duration was concerning and she immediately had KC stop pushing and they resolved and there was a significant improvement in the tracing.

9. Respondent testified she was reassured by this and left KC's bedside, but remained on the unit and was immediately available. Respondent testified she was paged at 2349 and the nurse casually reported KC still had variable decelerations with pushing. Respondent noted she went to KC's bedside, reassessed her and found a tracing markedly different than reported to her – it had late decelerations and the baseline was rising. Respondent testified she again asked KC to stop pushing so she could do an assessment and at 2349 and 2351 KC continued to push involuntarily and there was good variability that would indicate the infant was not acidotic.

10. Respondent noted there were late decelerations and it was clear something needed to be done at that point in time and she felt she had two options. The first was a C-section and the second was to assist with a vaginal delivery. Respondent testified KC made it very clear she was not interested in a C-section and her epidural was not working well, which would potentially further delay that. Respondent testified KC met all the criteria for a vacuum delivery and if the infant was in an occiput posterior position, which likely contributed to the variables she was having, the infant was easily rotated to an OA position, which would facilitate delivery. Respondent testified she placed the vacuum and began at 0028 and there was good progression with each effort. However, Respondent abandoned the vacuum after the third attempt in accordance with protocol when it popped off. Respondent testified the cord avulsion was a very significant factor and she believes KC was not emergent at 2251 and at 2349 when she reassessed her and felt it was necessary to deliver, she responded.

11. Respondent testified that in 2005 she served in a call group of five doctors who covered for each other and she would assume care for the patients at approximately 5:00 a.m. Respondent testified she is currently in private practice and has no contractual relationship or arrangement with any hospital and her office is about four miles away from the hospital. The Board asked Respondent if HD was admitted to the hospital at approximately 9:30 p.m., but not

seen by her until 8:00 a.m. the following morning. Respondent testified she did not have the record in front of her, but that sounded correct because if a patient is admitted at night it is unusual for the physician on-call to go to the hospital. Respondent testified normally the physician who assumes call in the morning sees the patient and admits the patient. The Board noted HD was preeclampic, had high blood pressures, had protein in her urine, and was placed on Pitocin drip magnesium sulfate via telephone orders. The Board asked is it was acceptable obstetrical care for a prima in active labor to not be seen by an obstetrician for almost twenty-four hours after her membranes ruptured or should someone have seen HD to evaluate her much earlier than Respondent actually did. Respondent testified it depends on the acuity of the patient's situation and she can honestly say she has never refused to see a patient when it was requested or when she felt it was pertinent. Respondent was asked if she was on-call would she have gone in to see HD. Respondent testified in all likelihood she would have.

12. The Board noted much of the review of both patients seemed to center around the interpretation of fetal heart monitoring, monitoring the patterns and the changes in the patterns regarding uterine contractions. The Board asked Respondent to explain how early deceleration and late deceleration occur in relationship to uterine contractions and the fetal heart rate and the significance or non-significance of decelerations especially if there is something more ominous the findings show to someone observing fetal heart rate patterns. Respondent testified an early deceleration occurs with a uterine contraction, will typically begin when the mother is at six to seven centimeters, and occurs secondary to head compression. Respondent testified it is a very mild dip in the heart rate tracing and essentially mirrors the contraction. Respondent testified they are normal, not ominous, and are present on every tracing.

13. Respondent testified a variable deceleration is a very abrupt drop in the fetal heart rate pattern that typically has a very quick return. Respondent testified they are variable in timing and do not always occur with a contraction, but frequently will. Respondent noted they tend to be

associated with cord compression and when they occur very early in labor she institutes maneuvers to try to take the pressure off the cord – such as repositioning a patient or inserting fluid back into the baby through an intrauterine pressure catheter or into the uterine cavity in order to take pressure off. Respondent testified they are very common in the second stage of labor and occur commonly secondary to a vagal response the baby gets from pushing and descending in the cavity. Respondent noted typically, as an isolated finding, they are not worrisome.

14. Respondent testified a late deceleration is the most ominous and looks very much like an early deceleration, but starts after the start of the contraction and reach nadir after the peak of the contraction and return late in timing. Respondent testified they tend to indicate a uteroplacental insufficiency – oxygen deprivation during that contraction – and will require some type of intervention. Respondent noted how she intervenes depends on what stage of labor the patient is in, how close the patient is to delivery, and in early labor, intervention would be a C-section. In late labor, she would attempt to reposition the patient, administer O2, or do a fluid bolus. Respondent noted there was an entire set of maneuvers she could try to resolve the issue and, if it resolved, labor would continue. If it was not resolved, she would need to intervene. The Board asked how safe it was to wait after taking steps to intervene in late decelerations to know there was a favorable response to the actions she had taken. Respondent testified there were no absolute guidelines with the exception of a particularly ominous pattern where a response, a delivery, is required within thirty minutes. Respondent testified in a situation where there are repetitive late decelerations and the baby appears to respond there is no absolute time limit as to how long is too long.

15. The Board directed Respondent to her medical records for HD, specifically the nursing entries and the labor and delivery flow sheet reflecting entries from 9:24 a.m. The Board asked Respondent to read the entry and explain its significance. The entry read "one deceleration for 4 minutes to the 60s with return to 120s for 1 minute, deceleration to 60s back to 130s – 140s

for 2 minutes and then deceleration to 60s for 45 seconds. [Fetal heart rate] returns to 140s for 4 minutes then deceleration to 80s for one minute with return to baseline . . ." Respondent testified she would have to see the tracings to see if she agreed with what was written in this note. The Board asked if the contents of the note caused concern. Respondent testified these readings occurred in the morning following HD's epidural placement and the nurse responded appropriately by giving uterine resuscitate measures and the baby was fine following this episode, which is not an uncommon occurrence. Respondent testified the nurses did not document any call to her and she did not have a specific recollection of the event, but it is not unusual for the nurses to institute the measures and once everything was better to call her or, if it did not get better, to call her and emergently ask her to come in. The Board confirmed the nurses would institute resuscitative measures to treat the abnormality without notifying Respondent or Respondent giving orders.

16. The Board directed Respondent to an entry in the record made on February 14 at 1502 that reads "[Decelerations] with [onset] late in [relationship to] peak of contraction present with 50% of contractions in last half hour" and asked her to explain the significance of the entry. Respondent testified it was a significant finding and something she should have been notified of and she believed the records indicate she was not notified and did not see HD until 1558 in response to a page she received while assisting in the other delivery. Respondent agreed this finding was a red flag and noted no resuscitative measures had been undertaken until her arrival. The Board noted the red flag occurred at 1502, approximately three hours prior to the actual C-section at 1810. Respondent testified there were absolutely no intrauterine resuscitative measures taking place at this time and when she instituted them there was mild improvement just as there had been earlier in the day, so while there were red flags, it is not uncommon to have red flags in labor. Respondent noted it was how she responded to those red flags, how frequent

they occur, that determine how acutely she needed to respond and how aggressively she needed to respond. Respondent testified she did respond.

17. The Board asked why, if as Respondent testified earlier, the nurses independently institute resuscitative measures, they did not institute such measures at 1502 and waited until she arrived at 1558. Respondent testified it was a different nurse taking care of HD at this time and she did not institute the measures although Respondent would have expected her to. The Board noted there was a definite red flag, no intrauterine measures were performed, the Pitocin was not turned off for at least two hours following the entry at 1502 and the C-section was not carried out for another three hours.

18. The Board directed Respondent to the letter submitted on her behalf by her expert. The Board noted the expert stated with great confidence that the baby was not acidotic when the fetal monitoring was discontinued, he felt there was no reason for Respondent to believe the fetus would become acidotic, and he speculated that something acute happened to cause the acidosis between the cessation of fetal monitoring at 1749 and the time of delivery at 1810. The Board noted this was directly opposite to Respondent's assessment of what happened because she felt, while the monitoring was still in place, that there were signs of both hypoxia and fetal distress and it was not an acute phenomenon. The Board also noted if it were to believe Respondent's expert then the delay of two hours is even more important because whatever happened would then have happened acutely between 1749 and 1810, a period of approximately twenty minutes. If so the two hour delay in delivery was contributory to the poor Apgar scores at the time of delivery. Respondent testified a hypoxic infant is one that is having late decelerations, something that can be corrected very typically by increasing perfusion. Respondent testified an acidotic infant is a more ominous sign and will occur with decreased variability. Respondent noted that unfortunately there are a lot of things that cause decreased variability and one very specific one is magnesium

sulfate, which HD was on. Respondent testified she does not know that she and the expert disagree so much since she was more concerned prior to the C-section then he indicates.

19. The Board asked Respondent if the baby was or was not acidotic as determined by the fetal heart monitors before they were removed at 1749 or was the baby fine up to that point and the hypoxemia and acidosis developed over the last twenty minutes before she delivered the baby. Respondent testified she did not know if she could ever answer that question and noted that seeing a very significant amount of fetal heart tracing all she knows is that it has increased the C-section rate. Respondent noted a good tracing will guarantee a good baby, but a bad tracing does not guarantee a bad baby. Respondent testified it is not an absolute science and is left open to interpretation.

20. The Board noted Respondent testified an impediment to her getting HD into the operating room was the hospital protocol, however Respondent did not provide the Board with a written copy of the protocol. The Board asked how the protocol impeded or precluded her from scheduling her patient for a concomitant C-section at the same time the other physician was performing a C-section. Respondent testified her use of "protocol" was probably incorrect and what she meant was it was a typical occurrence at the hospital. Respondent noted there are two rooms available and when she elects to do a C-section she notifies the charge nurse of her intent to proceed and the charge nurse can either block her or move her forward. Respondent testified it was a persistent problem that continues. The Board noted it would seem that if Respondent had a patient whose fetus was in distress she would let it be known that she needed the staff and an operating room to proceed with the C-section immediately and be more aggressive to make it happen regardless of any policy. Respondent testified she could not agree more, but there are delays that occur that prevent that from happening.

21. The Board noted the time from when the physician decides to perform the C-section to the time when the incision is made is referred to as "decision to incision" time and

asked Respondent the acceptable decision to incision time according to the American Society of Obstetrics and Gynecology ("ACOG"). Respondent testified it varies. The Board asked Respondent the difference between an "urgent C-section" and an "emergent C-section." Respondent testified there were no universal definitions of these terms and the definition used around the hospital is a routine C-section and either an urgent C-section or an emergent C-section – implying more of an emergency situation. Respondent noted ACOG does not have any definitive guidelines and there is simply the standard of care that in an emergent situation you be available within thirty minutes to proceed.

22. The Board noted Respondent's written response wherein she stated she was not updated of HD's status during the time she was assisting the other physician with a C-section and asked what her response would have been if she was contacted in the operating room. Respondent testified she would have gone to the other operating room where she expected HD to be and started the case. The Board asked if Respondent considered leaving the C-section (where she was assisting) at 1720 instead of 1810 and beginning HD's C-section at 1720. Respondent testified she could not say exactly what time she left the operating room, but she did leave before the other physician's case was over in anticipation of starting HD's case.

23. The Board note HD's baby had Apgars of two, possibly three, developed seizures, and because of seizures, cyanosis, and flaccidity, was transferred to another hospital where he remained for seven days until he was discharged. The Board asked Respondent to state reasons why a neonate can have seizures. Respondent testified the cause could be a hypoxic event in labor or a seizure disorder. Respondent testified it was her understanding that the nurse evaluating the baby in the nursery was concerned that it had a seizure and once the patient was transferred there was no subsequent seizure activity – the seizure activity was never confirmed to have ever occurred. The Board noted the records reflect the seizure was observed by both qualified nurses and physicians.

24. The Board directed Respondent to KC's records and noted it was surprised that with all that was going on with KC there are only two entries in Respondent's progress note – one is her admitting note and one is her delivery note. The Board also noted there is no documentation that KC was adamant against a C-section. Respondent testified she believed there were dictated admit notes and delivery notes that expand on each of these, but because she did not have them in front of her she could not say to what degree she dictated the consent.

25. The Board asked Respondent what she was trying to illustrate for the Board by providing pictures of the umbilical cord and placenta of KC's baby. Respondent directed the Board to the picture on the upper right-hand corner that shows a very dilated area, probably measuring three, three and one-half centimeters in width and further down where her two fingers are in the photograph it has become very straight and very thin and then it alternates again with a more bullous area. Respondent directed the Board to the pictures in the lower left-hand corner that emphasize even more where there is an extremely stenotic area that appears to be on the left-hand side then there is a very bullous area followed by a stenotic area and then another area that is a little more bullous. Respondent noted the stenotic areas are areas that appear to be completely devoid of Wharton's jelly, the protective jelly that surrounds the vessels within the cord. Respondent testified these photos illustrate a grossly abnormal umbilical cord.

26. The Board asked Respondent if it was correct that on examination at both the hospital where she performed the delivery and on transfer there were no external congenital abnormalities seen and therefore the gross abnormalities of the cord had no significance or impact on the development of the fetus. Respondent testified she believed that was correct, but only to the point that they had great difficulty passing umbilical artery catheters in the baby and that may have been a factor of the abnormal cord. Respondent testified it was a most unusual situation and she had never seen one like it before. Respondent also noted the infant does not undergo stress typically until they are undergoing the process of labor and when the uterus is

contracting, putting pressure on the cord at the time of delivery so it would not be unusual for this infant in a normal intrauterine environment to grow to a normal size and then not have impact on the cord until delivery. Respondent testified her point was that you would see repetitive variable decelerations in the second stage of labor all the time and that is something an infant would not undergo intrapartum at twenty-eight weeks.

27. The Board asked Respondent the significance of there being insufficient blood in the cord to obtain arterial blood gasses. Respondent testified when you say "insufficient in the cord" it means the cord had avulsed and there was only a very small area available at the level of the baby. Respondent noted when she gets cord gasses on a baby she typically clamps the cord in two locations and then gets a sample of that without any exposure to air whatsoever. Respondent noted in this case it was totally impossible because the cord had avulsed so close to the umbilicus she was not able to get it and basically the infant was unclamped for some portion of time because of this. The Board asked if a person could cause avulsion of the cord by rotating the fetus from occiput posterior to occiput anterior, especially in a cord with absence of normal cord twisting and abnormal decelerations due to cord compression. Respondent testified it was possible and she considered it, but there is no way as a physician you would even know you had an abnormal cord prior to delivery and, if in a normal situation, if there was a problem with the cord, the baby would not rotate, but this baby rotated very easily.

28. The Board asked Respondent what the autopsy of KC's baby revealed. Respondent testified she had not reviewed it in great detail and did not believe she had ever seen a copy of it, but a report from the hospital indicated the baby's death was caused by multi-organ failure. The Board asked Respondent how she would respond if she were faced today with the same set of circumstances, the same fetal monitoring patterns, the same delivery room and operating team, the same protocols, and considering both HD's and KC's cases. Respondent testified in the case of HD she believed she responded appropriately and if she had known about

the delays in the case she was assisting in and her own case she would have been more aggressive about getting HD into the operating room, but it is not unreasonable for her to have expected that things would have clicked along very rapidly. The Board asked if Respondent was saying she would do nothing differently with HD. Respondent testified she thought time was the critical issue in HD and she interpreted the tracing properly and intervened properly, but the question becomes how quick did she do it and the vast majority of that was beyond her control. Respondent testified she definitely would be more aggressive and she has been more verbal about her concerns and her documentation is much more complete that it ever has been before. Respondent testified she was capable of reading a tracing and of knowing how to respond and what to do, but when faced with roadblocks she needs to be more aggressive. Respondent testified with KC, knowing in retrospect the problems with the cord and what ultimately happened with the baby she would have done a C-section, but she does not believe her actions at the time where inappropriate and medically she thinks she did the correct thing at the time.

29. The Board noted its concern that with HD Respondent did not bump the C-section before her and do whatever she had to do to get HD into the operating room. The Board noted Respondent is the advocate for the patient and was concerned Respondent did not disregard the protocol and deal with the patient in distress. Respondent asked the Board to recall that the other patient was already being taken to the operating room and it would have necessitated her operating room being opened, HD taken back and being prepped for surgery, and while it seems that it should happen very fast, it does not always. Respondent testified she knew the flow at the hospital and knew that the quicker she helped the doctor doing the C-section before her the sooner she could get HD in. The Board asked Respondent why she did not "bump" the other C-section at the beginning and tell the other doctor she a patient in distress. Respondent testified it is something she has done in the past and HD's case could have worked better.

30. The Board asked in KC's case where there was fetal distress is that a sign that she should proceed to C-section or is it a sign that she continue to attempt to deliver vaginally. Respondent testified the question was whether you had a tracing that is non-reassuring and, if so, it is important that you do something about it and that depends on how close to delivery the patient is and how severe the situation is.

31. The Board confirmed that HD had hypertension, was on magnesium sulfate and Pitocin, and basically was not a routine labor and delivery patient. The Board asked how frequently Respondent checked her normal patients by phone or in person when she knows the patient is in labor. Respondent testified typically if it is during the day she will check on the patient first thing in the morning, at lunch, at the end of the day, and usually once in the evening. Respondent noted she will call staff if she has not heard from them in a while or particularly if they indicated there was a concern. The Board asked in less then a normal case, but not a severe case, how frequently does she monitor the patient. Respondent testified it varies significantly regarding the situation. The Board asked how many phone calls she made and how many times she showed up to see HD who was on magnesium sulfate and Pitocin and had fairly severe hypertension. Respondent testified she would have to go back through the record, but she knows she saw her in the morning and again around noon, and then again at 1748 and again at 20.

32. The Board asked if Respondent felt the continued Pitocin despite non-reassuring fetal strips was indicated for a number of hours after she saw the non-reassuring strip. Respondent testified she stopped the Pitocin at 1704, one hour after she began resuscitative measures and the Pitocin was at a very low level and HD had an intrauterine pressure catheter in place that was accurately measuring the strength of the uterine activity, which was minimal at that time. Respondent testified the standard is to discontinue the Pitocin and what is unique to HD is that she had decreased variability along with late decelerations and this occurred after the epidural was placed and there was a significant drop in her pressure. Respondent testified the

question then became is it something that is going to resolve as HD's pressure resolves and she performed intrauterine resuscitative measures. Respondent also noted there is a CST – contraction stress test – that she uses to assess the infant and in order to "fail" the test there must be repetitive decelerations occurring in greater than fifty percent of those contractions. Respondent noted that prior to her arrival this is was happening with HD, but they resolved with intrauterine resuscitative measures. Respondent noted the infant was not contracting very frequently and there was a baseline with decreased variability, but she did not know if it was caused by magnesium sulfate or it was an acidotic situation and she needed to do something to get her answer and by having Pitocin on by that period of time she believes the answer became apparent, that the lates resolved. Respondent then stated it did not become apparent and that was when she lost her comfort level.

16. The standard of care requires an obstetrician to recognize abnormal fetal heart tracings indicating fetal distress and deliver the fetus in a timely manner.

17. Respondent deviated from the standard of care because she did not recognize the abnormal fetal heart tracings indicated fetal distress and did not deliver the fetuses in a timely manner.

18. HD's baby had low Apgar scores, seizures, and a prolonged hospital stay and KC's baby died.

19. The Board noted as a mitigating factor that Respondent had taken proactive steps to enhance her interpretation of fetal heart tracings. The Board also noted Respondent's hospital privileges had been restored.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public") and 32-1401(27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient."

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

Respondent is issued a Letter of Reprimand for failure to recognize fetal distress and failure to promptly deliver two fetuses resulting in harm to one fetus and fetal death of the other.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that she has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-102. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 12th day of October, 2006.

THE ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 13th day of October, 2006 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Mail this 13th day of October, 2006, to:

Robert Milligan
Gallagher & Kennedy
2575 East Camelback Road
Phoenix, Arizona 85016-4240

Joan M. Warner, M.D.
Address of Record

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